UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF LOUISIANA
SHREVEPORT DIVISION

Akeem Henderson, et al. Plaintiffs; v. **Willis-Knighton Medical Center** Defendant.	Case No. 5:19-CV-00163 Judge Elizabeth E. Foote Magistrate Judge Mark L. Hornsby

AFFIDAVIT

Before me, the undersigned notary public, came and appeared,

SUSAN RAINER, RN

who after being duly sworn, did declare that:

1. I am a registered nurse ("RN") licensed in Louisiana and Texas. My curriculum vitae, attached as "Exhibit 1" accurately reflects my qualifications.
2. I have reviewed the medical records of A.H. from Willis-Knighton Medical Center South from the patient's February 10, 2018 emergency room treatment regarding the above-captioned matter, excerpts of which are attached as "Exhibit 2".
3. On February 10, 2018, I was working in the emergency department at Willis-Knighton South. A.H. presented to the emergency department at 1:54 a.m. with complaints of breathing difficulty and asthma exacerbation. I triaged the patient at 2:05 and assigned an Acuity of "2- Emergent." *Exhibit 2, p. 126.*
4. The patient was given a DuoNeb 1 unit dose inhalation immediately upon her arrival to the emergency department. *Exhibit 2, p. 122-123.* A Flu Test was negative. *Exhibit 2, p.*

131. At 2:32, the patient showed no adverse reaction to the DuoNeb, and her respiratory status was improving. *Exhibit 2, p. 127.*

5. The patient was seen by Dr. David Easterling, who ordered additional medications. At 3:16, I administered an Albuterol One Unit Dose – 2.5 mg inhalation to the patient. *Exhibit 2, p. 127.* I also administered Decadron – Dexamethasone Sodium Phosphate 4 mg IM once, at 3:44. The patient tolerated both medications well and her respiratory status improved. *Exhibit 2, p. 124-127.*

6. The patient's vital signs and respiratory function were continuously monitored the entire time A.H. was in the emergency department. At 3:23, the patient had the following vital signs: Pulse 145, Respirations 34, Pulse Ox 99%. *Exhibit 2, p. 126.*

7. After the patient was treated and her condition improved, the patient was discharged by Dr. Easterling to home with her family at 3:52 in stable condition. *Exhibit 2, p. 127*. In my opinion, there was no indication that the patient needed to be admitted to the hospital for further treatment.

8. Clear discharge instructions were given to the mother. I recall telling the family to watch the patient closely and return to the emergency department if her symptoms worsened. The patient's mother did not express any concerns at the time of A.H.'s discharge.

9. In my opinion, A.H. was in stable condition when discharged from Willis-Knighton South, and she did not appear to be in any respiratory distress at that time. While in the emergency department, I provided A.H. with breathing treatments, medications to treat asthma and bronchospasm, and monitored her until respiratory status had improved. An influenza test was negative. At the time of her discharge, A.H. was not experiencing respiratory distress and was in stable condition. I certainly did not have any knowledge

that this patient was unstable at the time of her discharge and would not have expected her to get worse after leaving the hospital.

10. I have worked with Dr. Easterling in the emergency department on other occasions. Based on my experience working with Dr. Easterling, I do not believe he would ever discharge a patient that was not stable or healthy enough to go home. If I had thought the patient would deteriorate, I would have said something to the doctor, and if I had thought he was sending home am unstable patient, I would have communicated it to my supervisors. In fact, I remember having a discussion with Dr. Easterling regarding whether the patient was ready for discharge, and we both agreed that she did not need to be admitted to the hospital and could be discharged because her condition had improved and stabilized.

11. I was not involved further in the patient's care following her discharge at 3:52 on February 10, 2018. I subsequently learned that during her treatment at Willis-Knighton Bossier and hospitalization, the patient was examined for signs of possible sexual abuse. At the time I treated the patient in the emergency department at Willis-Knighton South, there was no indication that the patient needed to be screened for abuse. I had prior experience working at a facility where I treated a high rate of abused children, and would have been quick to report suspected abuse and request a SANE examination if one was needed.

12. In the medical records containing my documentation for this patient, there is a section with "Corrections". If a correction is made to the electronic record after an initial entry is made, the record shows that a correction was made. Corrections to my entries made at 2:05 and 2:11 are shown on page 128 of the record, a copy of which is attached. Both

corrections were made to adjust the time. It is not unusual to update vital signs after treating a patient first. It's more important to treat the patient and then go back and make sure the information was entered correctly and that the time was accurate. For the 2:11 correction, I accidently clicked the patient was grunting, but she was not. The correction reflects that I changed my entry to fix that mistake. *Exhibit 2.*

13. I have independent recollection of this patient because I was surprised to hear she was later returned to the hospital in critical condition.

14. The foregoing is based on my personal knowledge, as well as my training, skills, and expertise as a registered nurse.

Susan Rainer RN
SUSAN RAINER, RN

WITNESSES:

(Signature)

B. Shields RN
(Signature)

Sherry Benson
(Printed Name)

B. Shields RN
(Printed Name)

SWORN TO AND SUBSCRIBED before me, the undersigned Notary, this 22 day of April, 2020, at 1734.

Marcie Anderson
NOTARY PUBLIC

MARCIE ANDERSON
Notary Public, State of Texas
Comm. Expires 07-18-2020
Notary ID 129058375

WILLIS-KNIGHTON HEALTH SYSTEM

CERTIFICATION OF MEDICAL RECORDS

I hereby certify that the attached medical record of:

A[redacted] H[redacted]

Is a true copy of the medical record on file at the WILLIS KNIGHTON SOUTH MEDICAL CENTER, 2510 BERT KOUNS IND LP, SHREVEPORT, LA 71118; that these records were prepared by the medical facility personnel during the course of business at or near the time of the visit; that I am the duly authorized Health Information Management Representative, and I have the authority to certify same.

10/4/19
Date

Patricia Lee, RHIT
Health Information Management Representative

WILLIS-KNIGHTON MEDICAL CENTER
SHREVEPORT, LA
EMERGENCY ROOM REGISTRATION INFORMATION (3008)

NAME: [redacted]

ACCT. NO: K20034594943

GUARANTOR: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821

NEXT OF KIN: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821 RELATION: PARENT

GUAR EMPLOYER: CHILD
ADDRESS:

PHONE:

ARRIVED FROM: C
ATTENDING PHYS: Easterling, David R M.D.
ADMIT/OTHER PHYS:
PRIM CARE PHYS:

	NAME	POLICY #	GROUP #	BENEFIT PLAN
PRIMARY INS:	LA HLTHCARE CONN LA ME	1997286459512	[redacted]	MEDICAID
SECONDARY INS:				
TERTIARY INS:				
FOURTH INS:				

ACCT NO: K20034594943
ROOM:
STATUS: REG ER

DATE: 02/10/18
TIME: 0154
SERV/LOC: ERS

UNIT#: K000629604
F/C: MA
SS#: [redacted]

PATIENT: [redacted]
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821

COUNTY: CADDO PARISH

BIRTHDATE [redacted]
AGE: 4Y
SEX: F
RACE BLACK OR AFRICAN AME
RELIGION: Other
MARITAL STAT: SINGLE

EMPLOYER: GOD'S GIFT
ADDRESS: 2305 MARIAN PL
SHREVEPORT,LA 71109
000-0000

PERSON TO NOTIFY: ALEXANDER,JENNIFER
ADDRESS: 2247 LEGARDY STREET
SHREVEPORT,LA 71107
PHONE: (318)210-3821 RELATION: PARENT

Is the Patient here for Pre-Op Testing: N
Comments:
Reason for Visit: BREATHING DIFFICULTY,ASTHMA EXACERBATION
Admit Clerk: PATERA.AM
Baby ID#:
Known Drug Allergies: NKDA HIPPA Notice Given: Y Date Notice Given: 08/23/14 Device Id: AMSPC5
Interpreter ID Number: Patient Survey: N Preferred Language: ENGLISH Ethnicity: NHILAT
Do you have an advaced directive that you would like to present to us today? N

K20034594943

Physician Documentation ***Willis Knighton South***

Name: [redacted]
Age: 4 yrs **Sex:** Female **DOB:** [redacted]
Arrival Date: 02/10/2018 **Time:** 01:54
Bed 20

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

HPI:

02/10 02:33 This 4 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Breathing Difficulty, Asthma Exacerbation**. dre/mj2

02:33 The patient presents to the emergency department with cough, wheezing. Onset: The symptoms/episode began/occurred at 00:00. Associated signs and symptoms: Pertinent positives: cough, wheezing, Pertinent negatives: abdominal pain, body aches, chest pain, constipation, diarrhea, dysuria, earache, fever, headache, myalgias, nasal discharge, seizure, sore throat, vomiting. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. The patient has experienced a previous episode. The patient has been recently seen by a physician: SEEN AT QUICK CARE THURSDAY, DX WITH URI/STREP GIVEN Z PAK. HX AUTISM, ASTHMA, HAS BREATHING MACHINE AT HOME-ALBUTEROL, ONE TX PTA. dre/mj2

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Inhl as needed
  2. dulera 2 puffs am and 2 puffs pm
  3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

ROS:

02:33 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Eyes:** Negative for injury, pain, redness, and discharge, **ENT:** Negative for injury, pain, and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache; weakness, numbness, tingling, and seizure. **Constitutional:** Positive for coughing, shortness of breath, Negative for chills, fatigue, malaise, acute pain, poor PO intake, vomiting, weight loss. **Respiratory:** Positive for cough, wheezing, Negative for dyspnea on exertion, hemoptysis, orthopnea, pleurisy, paroxysmal nocturnal dyspnea, sputum production. dre/mj2

Exam:

02:33 dre/mj2

Head/Face: Normocephalic, atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla
Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

Physician Documentation Con't.

Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses intact and symmetrical throughout. No edema or JVD.
Abdomen/GI: Soft, non-tender, nondistended, no mass, no hepatosplenomegaly. No rebound or guarding. Bowel sounds present all quadrants. No hernia noted
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.
MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Joints show full, normal range of motion. Good muscle tone and strength. No acute changes of nails or digits
Neuro: Awake or easily awakened, alert, makes good eye contact, age appropriate reflexes, good tone, easily consolable.
Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well groomed, well hydrated, well nourished, non-diaphoretic, non-toxic, afebrile.
Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, symetrical, no use of accessory muscles, no grunting, no evidence of nasal flaring, no appreciated paradoxical movements, no prolonged exhalations, no pursed lip breathing, no retractions, no shallow respirations, no splinting, no tachypnea, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, wheezing, that is mild, bronchial sounds, are not appreciated, decreased breath sounds, are not appreciated, stridor, is not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91% on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm) sr11
02:05 100% breathing treatment sr11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
02:05	spontaneous(4)	oriented(5)	obeys commands(6)		15	sr11

MDM:

02:30 Patient medically screened. dre

02:33 dre/mj2
Data interpreted: Pulse oximetry: on room air observed by me at the bedside is 91 %.

03:50 dre
Differential diagnosis: bacterial infection, bronchitis, fever, gastroenteritis, pneumonia URI, UTI, viral Infection.
Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up.
Response to treatment: the patient's symptoms have resolved after treatment, the patient's condition has returned to base line.

Order	Status	Time	By	For
DuoNeb 1 unit dose Inhalation once	Ordered	02/10/18 02:04	sr11	dre
	Administered	02/10/18 02:04	sr11	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Easterling, David, MD 02/10/18 02:31			

Physician Documentation Con't.

Drug alert over ride reasons: Clinically indicated

02/10/18 02:04 **Administered:** DuoNeb 1 unit dose Inhalation sr11

02/10/18 02:32 **Follow Up:** Response: No Adverse Reaction; Respiratory status improved; Tolerated well sr11

Order	Status	Time	By	For
Influenza by PCR	Ordered	02/10/18 02:31	dre	dre
	Reviewed	02/10/18 03:10	David Easterling	
Notes:	**Order Method:** Electronic			

Interpretation: negative.
Ordering Location: ERSPC100.1
Priority LAB: Stat
Collected by Nurse? (Yes - Change to No for Lab Collect): Yes
Specimen Source (LBFLUSPEC): Nasopharynx

Order	Status	Time	By	For
COLLECT SWAB	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:32	Susan Rainer	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	02/10/18 02:31	dre	dre
	In Process Unspecified	02/10/18 03:39	Dispatcher MedHost	
Notes: Bed Name: 20	**Order Method:** Electronic			

Interpretation: perihilar infiltrates, otherwise negative .
Is the patient able to bear weight? (OERDBEARWT):
Is the patient at risk for falls? (OERDFALLS):
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher
O2: (OEADO2): No
Priority RAD: Stat
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty, Asthma Exacerbation
WEIGHT? : (OERDWEIGHT): 18.14
ER EXAM ROOM/BED: (OERDERRMBD): 20

Order	Status	Time	By	For
Call X-Ray Tech	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:36	Susan Rainer	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation once	Ordered	02/10/18 03:11	dre	dre
	Administered	02/10/18 03:16	sr11	
Notes:	**Order Method:** Electronic			

Physician Documentation Con't.

02/10/18 03:16	**Administered:** Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation	sr11
02/10/18 03:55	**Follow Up:** Response: No Adverse Reaction; Respiratory status improved; Tolerated well	sr11

Order	Status	Time	By	For
Decadron - Dexamethasone Sodium Phosphate 4 mg IM once	Ordered	02/10/18 03:12	dre	dre
	Administered	02/10/18 03:44	mh7	
Notes:	**Order Method:** Electronic			

02/10/18 03:44	**Administered:** Decadron - Dexamethasone Sodium Phosphate 4 mg IM in left ventrogluteal	mh7
02/10/18 04:00	**Follow Up:** Response: No Adverse Reaction; Tolerated well	sr11

Order Signatures:

Easterling, David, MD	MD	dre	Rainer, Susan, RN	RN	sr11

Scribe Statement:

02/10
02:13 Scribed for **Dr. David R Easterling, MD** by Morgan Jaudon, Scribe dre/mj2

Disposition:

03:50 Electronically signed by: David Easterling, M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. dre

Disposition:

02/10/18 03:52 Discharged to Home/Self Care. Impression: Acute bronchospasm.

- Condition is Stable.
- Discharge Instructions: Bronchospasm, Pediatric.
- Prescriptions for
  prednisolone 15 mg/5 mL Oral Solution
  - take 10 milliliter by ORAL route once daily for 5 days with food; 50 milliliter.
- Follow up: Allen, Scott; When: 2 days; Reason: Recheck today's complaints.
- Problem is an acute exacerbation.
- Symptoms are resolved.

Signatures:

Dispatcher MedHost		EDMS	Easterling, David, MD	MD	dre
Jaudon, Morgan, Scribe	Scribe	mj2	Harmon, Melissa, RN	RN	mh7
Rainer, Susan, RN	RN	sr11			

Corrections:

03:52 ~~03:52 02/10/2018 03:52 Discharged to Home/Self Care. Impression: Acute bronchospasm. Condition is Stable. Follow up: Scott Allen; When: 2 days; Reason: Recheck today's complaints. Problem is an acute exacerbation. Symptoms are resolved.~~ ~~dre~~ dre

Nurse's Notes

Name: [redacted]
Age: 4 yrs **Sex:** Female **DOB:** [redacted]
Arrival Date: 02/10/2018 **Time:** 01:54
Bed 20

Willis Knighton South

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

Presentation:

02/10 02:05 Preferred language for medical communication is English. Presenting complaint: Mother states: woke up at midnight wheezing and coughing, i took her to quick care the other day, she has strep throat and URI, shes been taking a z pack, gave breathing treatment at home with no relief, pt currently sitting in tripod position. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: Medications: Albuterol Neb. sr11

02:11 Acuity: 2 - Emergent. sr11

02:15 Method of Arrival: Ambulatory. sr11

Triage Assessment:

02:05 **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Pain:** level that is acceptable is 0 out of 10 on a pain scale. sr11

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Inhl as needed
  2. dulera 2 puffs am and 2 puffs pm
  3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

Screening:

02:05 **Abuse screen:** sr11
Denies threats or abuse. Denies injuries from another. there are no obvious signs of child abuse.
Patient fall risk assessment;
No risks identified.
Learning Barriers:
No barriers to teaching and learning identified.
Pedi Fall Risk
No risks identified.
Exposure risk/Travel Screening:
No exposures identified.

Assessment:

02:11 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, obeys commands. **EENT:** Reports Sore Throat Parent/caregiver reports the patient having nasal congestion nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers Rhythm is sinus tachycardia. **Respiratory:** Respiratory effort is labored, with retractions, using tripod position, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. sr11

02:33 **Respiratory:** Reassessment: Patient states symptoms have improved. sr11

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91% on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm) sr11

Nurse's Notes Con't

02:05 100% breathing treatment sr11

Vitals:

02:05 Acuity: 2 - Emergent. sr11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
02:05	spontaneous(4)	oriented(5)	obeys commands(6)		15	sr11

ED Course:

01:54 Patient arrived in ED. ms2

01:54 Patient moved to KIOSK. ms2

02:04 Patient moved to 20. sr11

02:04 Rainer, Susan, RN is Primary Nurse. sr11

02:11 Triage completed. sr11

02:11 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Child being held by parent. Pulse oximetry, Bedside monitor alarms on and audible. sr11

02:13 Easterling, David, MD is Attending Physician. dre

02:15 Allen, Scott is Private Physician. sr11

02:33 Influenza culture sent to lab. sr11

02:46 Patient moved to Radiology. jat

02:46 Chest 2 View *routine* Sent. jat

03:29 Patient moved to 20. jat

03:51 Allen, Scott is Referral Physician. dre

03:59 No procedures done that require assistance. sr11

Administered Medications:

Time	Drug & Dose *Dispensable & Quantity*	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
02:04	DuoNeb 1 unit dose		Inhalation					sr11
02:32	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:16	Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg		Inhalation					sr11
03:55	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:44	Decadron - Dexamethasone Sodium Phosphate 4 mg		IM			left ventrogluteal		mh7
04:00	Follow up: Response: No Adverse Reaction; Tolerated well							sr11

Outcome:

03:52 Discharge ordered by MD. dre

03:59 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 1, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. sr11

Nurse's Notes Con't

04:00 Electronic medical record closed. sr11

Signatures:

Easterling, David, MD	MD	dre	Scriptuser, MEDHOST		ms2
Torres, Jose		jat	Jaudon, Morgan, Scribe	Scribe	mj2
Harmon, Melissa, RN	RN	mh7	Rainer, Susan, RN	RN	sr11

Corrections:

02:20 ~~02:05~~ ~~Pulse 156bpm; Resp 36bpm; Pulse Ox 91% RA; 18.14 kg; Height 3 ft. 2 in.; BMI: 19.4; 100% breathing treatment;~~ ~~sr11~~ sr11

02:22 ~~02:11~~ ~~Respiratory: Respiratory effort is labored, with retractions, grunting, using tripod position, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally.~~ ~~sr11~~ sr11

RUN DATE: 02/13/18 **WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES** **PAGE** 1
RUN TIME: 0207 WKHS Summary Discharge Report
WK=2600 Greenwood Rd **WKS=2510 BertKounsIndLoop** **WKB=2400 Hospital Dr** **WKP=8001 Youree Dr**
Shreveport,LA 71103 **Shreveport, LA 71118** **Bossier City, LA 71112** **Shreveport,LA 71115**

PATIENT: [redacted] **ACCT #:** K20034594943 **LOC:** ERS **U #:** K000629604
DOB: [redacted] **AGE/SX:** 4Y 04M/F **ROOM:** **REG:** 02/10/18
ATT DR: Easterling, David R M.D **STATUS:** DEP ER **BED:** **DIS:**

Point of Care Testing

Date / Time	FEB 10 1636	FEB 10 1306	Reference	Units
Bedside Glucose	280 H		(70-110)	mg/dL
FIO2		50%	(ROOM AIR)	%
pH		6.91 L	(7.31-7.41)	
pCO2		88 H	(41-51)	mmHg
pO2		33	(25-40)	mmHg
BE		-15.0 L	(-2-2)	mmol/L
HCO3		18 L	(24-38)	mmol/L
TCO2		20 L	(25-29)	mmol/L
Ionized Calcium		0.87 L	(1.12-1.32)	mmol/L
Sodium		146 H	(136-145)	mmol/L
Potassium		6.7(A)HH	(3.5-5.1)	meq/L

(A) Point of Care Critical Value-Communication of critical values for Point of Care Testing is the responsibility of the device operator. Documentation will be found in the patient's medical record.

Glucose		250 H	(70-110)	mg/dL
Hematocrit		30.0 L	(38-51)	%

Date / Time	FEB 10 1143	FEB 10 1101	Reference	Units
Bedside Glucose	408(B)HH	43(B)LL	(70-110)	mg/dL

(B) Point of Care Critical Value-Communication of critical values for Point of Care Testing is the responsibility of the device operator. Documentation will be found in the patient's medical record.

Laboratory recommends confirmation at the following ranges:

<60mg/dL - >350mg/dL
(NICU Only) <40mg/dL - >350mg/dL

** CONTINUED ON NEXT PAGE **

RUN DATE: 02/13/18 **WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES** **PAGE** 2
RUN TIME: 0207 WKHS Summary Discharge Report
WK=2600 Greenwood Rd **WKS=2510 BertKounsIndLoop** **WKB=2400 Hospital Dr** **WKP=8001 Youree Dr**
Shreveport,LA 71103 **Shreveport, LA 71118** **Bossier City, LA 71112** **Shreveport,LA 71115**

PATIENT: [redacted] **ACCT #:** K20034594943 **LOC:** ERS **U #:** K000629604
DOB: [redacted] **AGE/SX:** 4Y 04M/F **ROOM:** **REG:** 02/10/18
ATT DR: Easterling, David R M.D **STATUS:** DEP ER **BED:** **DIS:**

PCR TESTS

Date / Time	FEB 10 0230	Reference	Units
Flu A	Negative	(Negative)	
Flu B	Negative	(Negative)	
Flu Comments	Comments(C)		

(C) NEGATIVE influenza test results do not preclude influenza virus infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.

Comments See Below(D)

(D) The results of this assay should be interpreted in conjunction with other laboratory and clinical data.

** END OF REPORT **

RUN DATE: 02/11/18 **WILLIS-KNIGHTON HEALTH SYSTEM LABORATORIES** **PAGE** 1
RUN TIME: 0206 WKHS Summary Discharge Report
WK=2600 Greenwood Rd **WKS=2510 BertKounsIndLoop** **WKB=2400 Hospital Dr** **WKP=8001 Youree Dr**
Shreveport,LA 71103 **Shreveport, LA 71118** **Bossier City, LA 71112** **Shreveport,LA 71115**

PATIENT: [redacted] **ACCT #:** K20034594943 **LOC:** ERS **U #:** K000629604
DOB: [redacted] **AGE/SX:** 4Y 04M/F **ROOM:** **REG:** 02/10/18
ATT DR: Easterling, David R M.D **STATUS:** DEP ER **BED:** **DIS:**

PCR TESTS

Date / Time	FEB 10 0230	Reference	Units
Flu A	Negative	(Negative)	
Flu B	Negative	(Negative)	
Flu Comments	Comments(A)		

(A) NEGATIVE influenza test results do not preclude influenza virus infection and should not be used as the sole basis for treatment or other patient management decisions. False negative results may occur if virus is present at levels below the analytical limit of detection or the virus mutates in the target region.

Comments See Below(B)

(B) The results of this assay should be interpreted in conjunction with other laboratory and clinical data.

** END OF REPORT **

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118

Patient Name: [redacted]
Adm No: K20034594943
DOB: [redacted]
Age: 4Y F
Corp ID: 000001116206

MRN: 1116206
Location: ER Patient - -
Ord No: 90022
Hospital: WKS

Ordering Dr: DAVID RANDALL EASTERLING CC:

Final Report

Admitting Diagnosis: BREATHING DIFFICULTY,ASTHMA EXACERBATION
Reason For Exam: Breathing Difficulty, Asthma Exacerbation
Procedure Date: 02/10/2018
Procedure: SXR - XR, chest 2 view

Interpretive Location: BOS
Accession Number: 3960557
CPT Code: 71046

IMPRESSION: No acute cardiopulmonary disease.

RESULT:

Procedure: XR, chest 2 view

Clinical Information: Breathing Difficulty, Asthma Exacerbation

Comparison: 12/6/2017

Findings:
Heart size and contour are within normal limits. The lungs are clear of infiltrate, mass lesion, or effusion. No significant skeletal abnormality is seen.

Electronically Signed by: CORNELIUS J BOS M.D. on Feb 10 2018 5:30A

Techs: Jose A Torres
Additional Staff:

Read by: CORNELIUS J BOS M.D. on Feb 10 2018 5:30A
Electronically Signed by: CORNELIUS J BOS M.D. on Feb 10 2018 5:30A

Printed: Feb 10 2018 5:34AM

ALLERGY REPORT

Pt Name:	[redacted]	**MRN:**	1116206
Pt ID:	0101757329	**Acct No:**	K20034594943
DOB:	[redacted]	**Age/Sex:**	4Y/F
Adm DTime:	02/10/2018 01:54	**Atn Dr:**	Easterling, David MD
Nurs Sta:	Willis-Knighton South	**Rm & Bed:**	
Dx:			
Alrg:	codeine, Fish Containing Products, Fish containing products		

Alrg Type	Alrg Name	Onset	Reaction	Severity	Comment
Drug	codeine	7/14/2017	Shortness of Breath	Severe	"Took codeine yesterday. Started wheezing, couldnt breathe like she was having an asthma attack"
Drug	Fish Containing Products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood
Food	Fish containing products	05/2017	Anaphylaxis	Severe	Patient severely allergic. Reaction when touches seafood

RUN DATE: 02/[redacted]/18
RUN TIME: 0219
RUN USER: PATERA.AM

[redacted]lis Knighton [redacted]th *ADMISSION[redacted]

INTERDISCIPLINARY ALLERGY SOURCE DOCUMENT

[redacted]

Name: [redacted]
Rm/Bd:
Unit#: K000629604
Serv/Locn: ERS
Account#: K20034594943
DOB: [redacted]
Status: ER
EPI#: 000000001116206
Age: 4Y 04M
Sex: F

Interdisciplinary Assessment (Free Text), historical data:	Last Update/ Acknowledgement:
Allergy1-Med/Contact: NKDA	11/04/16 - 2201
Allergy2-Med/Contact: NKDA	11/04/16 - 2201
Food Allergies-Intol: NKFA	11/04/16 - 2201
Latex Allergy (Y/N): N	11/04/16 - 2201

Pharmacy Allergy List (Coded Allergies), historical data: 11/06/16
(Duplicate names represent coding within (3) categories:
Ingredient, Generic and Class allergy codes.)

NO KNOWN DRUG ALLERGIES, NO KNOWN FOOD ALLERGIES, NO KNOWN LATEX ALLERGY

Interdisciplinary Allergy Source Document is a Permanent Part of the Patient's Medical Record

[redacted]

Easterling, David R
K20034594943 02/10/18

Willis Knighton South and Center for Womens Health

Willis Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
318-212-5500

Discharge Instructions for: [redacted]
Arrival Date: 02/10/2018 01:54
Care Complete Time: 02/10/2018 03:52

Thank you for choosing **Willis Knighton South** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Easterling, David, MD
Diagnosis: Acute bronchospasm

DISCHARGE INSTRUCTIONS	FORMS
Bronchospasm, Pediatric	None
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Allen, Scott When: 2 days; Reason: Recheck today's complaints	prednisolone
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).

[redacted] Henderson
MRN # 1116206

Susan Rain RN
ED Physician or Nurse

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Chart Copy

[redacted]
Easterling, David R
K20034594943 02/10/18

FOLLOW UP INSTRUCTIONS

Allen, Scott
When: 2 days
Reason: Recheck today's complaints

PRESCRIPTIONS

TESTS AND PROCEDURES

Labs
Influenza by PCR

Rad
Chest 2 View *routine*

Procedures
Pulse Ox Continuous

Other
COLLECT SWAB, Call X-Ray Tech

[redacted]
Easterling, [redacted] 02/10/18
K20034594943